

## **P-IRO Inc.**

**An Independent Review Organization**

**Phone Number:**  
**(817) 779-3287**

**1301 E Debbie Lane Suite 102 PMB 203**  
**Mansfield, TX 76063**  
**Email: [p-iro@irosolutions.com](mailto:p-iro@irosolutions.com)**

**Fax Number:**  
**(817) 385-9612**

### ***Notice of Independent Review Decision***

**Case Number:**

**Date of Notice:** 06/20/2016

#### ***Review Outcome:***

***A description of the qualifications for each physician or other health care provider who reviewed the decision:***

Physican Medicine And Rehab

#### ***Description of the service or services in dispute:***

Transforaminal ESI Rt L5-S1 with sedation

***Upon Independent review, the reviewer finds that the previous adverse determination / adverse determinations should be:***

- ☒ Upheld (Agree)
- ☐ Overturned (Disagree)
- ☐ Partially Overturned (Agree in part / Disagree in part)

#### ***Patient Clinical History (Summary)***

The patient is a female who reported an injury on XX/XX/XX. The mechanism of injury was not provided in the medical records. The patient was diagnosed with radiculopathy of the lumbar region. A CT of the lumbar spine was performed on XX/XX/XX which noted a 5 mm posterior disc protrusion seen with impression on the anterior aspect of the thecal sac at the L5-S1 level, degenerative facet joint changes were identified. No central canal stenosis was identified. There was moderate bilateral neural foraminal narrowing. According to the lumbosacral myelogram performed on XX/XX/XX, the posterior disc bulges or disc protrusions were identified at the L5-S1 level. The evaluation performed on XX/XX/XX indicated the patient continued to have complaints of low back pain and right lower extremity pain that had progressively worsened. She continued to have difficulty with placing weight on the lower extremity due to pain and weakness. On the physical examination, lumbar range of motion was painful and restricted. Straight leg raise was positive on the right side at 45 degrees. Pain with seated straight leg raise was located at the back, buttocks and thigh. Straight leg raise was positive on the left side at 60 degrees. EHL/peroneus strength and gastrocsoleus strength was noted to be 4+ on the right. Current right gluteus strength was 5. Right ankle reflexes were hypo. The patient's treatment plan included a transforaminal injection on the right at the L5-S1 level to reduce pain in the right lower extremity.

***Analysis and Explanation of the Decision include Clinical Basis, Findings and Conclusions used to support the decision.***

According to Official Disability Guidelines, epidural steroid injections are recommended as an option for treatment of radicular pain for patients who are initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs, and muscle relaxants). The guidelines also state radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. The documentation submitted for review indicated the patient complained of low back pain with right lower extremity pain that progressively worsened. The patient had imaging findings of disc protrusion or disc bulge at the L5-S1 level. The patient was noted to have restricted range of motion and positive straight leg raise on the right at 45 degrees, and decreased EHL/peroneus and gastrocsoleus strength on the right. However, there

was no documentation of any recent failed conservative treatment such as physical therapy. Also, the documentation failed to provide findings of extreme anxiety to warrant the need of sedation. Therefore, the request is not supported. As such, the request for transforaminal ESI right L5-S1 with sedation is non-certified and the previous determination is upheld.

***A description and the source of the screening criteria or other clinical basis used to make the decision:***

- ☐ ACOEM-America College of Occupational and Environmental Medicine um
- ☐ knowledgebase AHCPR-Agency for Healthcare Research and Quality Guidelines
- ☐ DWC-Division of Workers Compensation Policies and
- ☐ Guidelines European Guidelines for Management of Chronic
- ☐ Low Back Pain Interqual Criteria
- ☒ Medical Judgment, Clinical Experience, and expertise in accordance with accepted medical
- ☐ standards Mercy Center Consensus Conference Guidelines
- ☐ Milliman Care Guidelines
- ☒ ODG-Official Disability Guidelines and Treatment
- ☐ Guidelines Pressley Reed, the Medical Disability Advisor
- ☐ Texas Guidelines for Chiropractic Quality Assurance and Practice
- ☐ Parameters Texas TACADA Guidelines
- ☐ TMF Screening Criteria Manual
- ☐ Peer Reviewed Nationally Accepted Médical **Literature** (Provide a description)
- ☐ Other evidence based, scientifically valid, outcome focused guidelines (Provide a description)